



THE COMMONWEALTH OF MASSACHUSETTS

TOWN OF HAMILTON**FISCAL YEAR 2027**

ASSESSOR USE ONLY

Parcel I.D. _____
Date Received _____

LOW INCOME PERSONS-LOW OR MODERATE INCOME SENIORS

FISCAL YEAR 2027 APPLICATION FOR COMMUNITY PRESERVATION ACT EXEMPTION

General Laws Chapter 44B

Application must be filed 3 months after the actual (not preliminary) tax bills are mailed for fiscal year.

1. IDENTIFICATION: (Complete all sections fully)

Name of Applicant _____

Mailing Address _____ Tel. No. _____

Marital Status _____

Were you 60 years or older on January 1, 2026? Yes _____ No _____

If yes and first year of application, please attach a copy of birth certificate.

Legal Residence (Domicile) on January 1, 2026 _____

Location of Property _____

Did you own the property on January 1, 2026? Yes _____ No _____

If yes, were you: Sole Owner: _____ Co-Owner with Spouse Only _____ Co-Owner with Others _____

Was the property held in trust as of January 1, 2026? Yes _____ No _____

(If yes, attach instrument including all schedules)

Have you been granted any exemption in any other city or town (MA or other) for this fiscal year? Yes _____ No _____

If yes, name of city or town _____ Type of exemption _____

2. INCOME**GROSS INCOME FROM ALL SOURCES IN CALENDAR YEAR 2025 FOR EACH MEMBER OF FAMILY** (EXCEPT FULL TIME STUDENTS AND MINOR CHILDREN) AS FOLLOWS: Retirement Benefits (Social Security, Railroad, Federal, Mass, and Political Subdivisions), Other Pensions and Retirement Allowances, Wages, salaries and Other Compensation, Net Profits from Business or Profession, Interest and Dividends, Alimony, Child Support, Rental income, Capital gains, and other.**Total Number of persons residing in Household:**

Name: First, Middle, Last	Relationship To Applicant	Date of Birth	Annual Total Income (All Sources)
	Applicant		
	Spouse		
TOTAL FAMILY GROSS INCOME:			\$

3. DEPENDENT DEDUCTION (Please list all dependents residing in household)

NAMES:	DATE OF BIRTH	FULL TIME STUDENT?	
_____	_____	Y	N
_____	_____	Y	N
_____	_____	Y	N
_____	_____	Y	N
_____	_____	Y	N
_____	_____	Y	N

4. MEDICAL EXPENSE DEDUCTION

DEDUCTIONS FOR MEDICAL EXPENSES OF ALL FAMILY MEMBERS IN CALENDAR YEAR 2025

Note: Do not include amounts that have been reimbursed or paid by insurance

Health Insurance Premiums	\$ _____
Hospitals	\$ _____
Doctors	\$ _____
Prescription Drugs	\$ _____
Medical Equipment	\$ _____
Other	\$ _____
TOTAL MEDICAL EXPENSES:	\$ _____

DID YOU, OR ANY MEMBER OF YOUR FAMILY FILE A **FEDERAL INCOME TAX RETURN (S) FOR CALENDAR YEAR 2025?** YES _____ NO _____ IF YES, **A COPY OF PAGE ONE OF THAT RETURN IS REQUIRED FOR ALL FAMILY MEMBERS.** (TAX RETURN INFORMATION WILL BE DESTROYED AFTER FINAL DISPOSITION OF THE APPLICATION)

PLEASE NOTE: INFORMATION ON THIS FORM IS NOT SUBJECT TO PUBLIC INSPECTION.

SIGNATURE: (Sign below to complete application)

This application has been prepared or examined by me. Under the pains and penalties of perjury, I declare that to the best of my knowledge and belief, it and all accompanying documents and statements are true.

Signature(s)

Date

**** Filing this application does not stay the collection of your surcharge. To avoid interest and collection charges, you must pay surcharge as billed by the due date. If the exemption is granted and the surcharge is paid in full, then a refund will be made.**